## Appendix 6

## Sample HCFA 1500 Claim Form-Medical Direction With Third Surgery Begun During Procedure

PICA						н	EALTH I	INS	URANCE CI	LAIM	FORM	ı		PICA	
1. MEDICARE N	MEDICAID CH	IAMPUS		CHAMPVA	GROUF	FE(	CA OT	THER	1a. INSURED'S I.D. N	UMBER		(FOR P	ROGRAM	IN ITEM 1)	
(Medicare #) P (A		onaor'a S		(VA File #	) HEALTH (SSN of	or ID) (S	SSN) (IE	·	123456789 4. INSURED'S NAME		First Norm		In int all N		
Recipient, Im		, mode i	iiillai)		MM DI	YY	X SEX	<b>-</b>	4. INSURED S NAME	(Last Ivar	ne, riistinali	ie, ivildaie	initiat)		
5. PATIENT'S ADDRESS		6. PATIENT RELATIONSHIP TO INSURED  Set Spouse Child Other				7. INSURED'S ADDRESS (No., Street)									
CITY				STATE	8. PATIENT ST				CITY					STATE	
Anytown					Single	Married	Other	- I					ľ	SIAIE	
ZIP CODE	TELEPHONE (Include Area Code)				Employed	— Full-Time —	Part-Time	_ [	ZIP CODE		TELEPHO	ONE (INCI	LUDE ARE	A CODE)	
55555  (XXX)XXX-XXXX  O OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						Student	Student	_			(				
OI-P	NAME (Last Name, Fi	rst Name	e, Middle	initial)	10. IS PATIEN	T'S CONDITION	HELATED TO:		11. INSURED'S POLIC	OY GHOU	JP OH FECA	NOWBER	1		
a. OTHER INSURED'S	POLICY OR GROUP	NUMBER	Ŧ		a. EMPLOYME	NT? (CURRENT	OR PREVIOUS	3)	a. INSURED'S DATE O	OF BIRTH	1		SEX	•	
					YES NO			-	M F L						
b. OTHER INSURED'S DATE OF BIRTH SEX					b. AUTO ACCIDENT? PLACE (State)				b. EMPLOYER'S NAME OR SCHOOL NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME						
6. EWI ESTERIO NAME STOSTOSE NAME					YES NO				S. HOSE FERNING OFF HOMEWAY						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
									YES NO If yes, return to and complete item 9 a-d.						
12. PATIENT'S OR AUT to process this claim. below.	READ BACK OF F HORIZED PERSON'S I also request paymen	S SIGNA	TURE I	authorize the r	elease of any me	edical or other inf		ary	<ol> <li>INSURED'S OR All payment of medica services described</li> </ol>	l benefits					
SIGNED DATE									SIGNED						
14. DATE OF CURRENT	DATE OF CURRENT: ILLNESS (First symptom) OR IS. IM   DD   YY   INJURY (Accident) OR   PREGNANCY(LMP)					IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY				FROM DD YY TO MM DD YY					
17. NAME OF REFERRI	NG PHYSICIAN OR	OTHER 8	OURCE	17a.	I.D. NUMBER C	F REFERRING	PHYSICIAN		18. HOSPITALIZATION MM DE FROM	N DATES YY			DD		
19. RESERVED FOR LO	DCAL USE			1					20. OUTSIDE LAB?		\$ CI	HARGES			
	· -									NO					
21. DIAGNOSIS OR NA	TURE OF ILLNESS C	OR INJUE	RY. (REL	ATE ITEMS 1,	2,3 OR 4 TO IT	EM 24E BY LINE	=)		22. MEDICAID RESUB CODE	imissior 	ORIGINAL	REF. NO	).		
1. 575.1					3,				23. PRIOR AUTHORIZATION NUMBER						
2			T 0	4.	L	_	) E	- 1	<sub>F</sub>	l G	нГТ		1		
24. A DATE(S) OF From	SERVICETO	Place				, OR SUPPLIES	DIAGNOSI	IS	·		EPSDT	-	RESER	K RVED FOR	
MM DD YY	MM DD YY		of Service	CPT/HCPC	S   MODIF	TER	CODE	500	\$ CHARGES	UNITS	Plan EM	G COB	<del> </del>	AL USE	
MMDD YY		1	7	47600	) W2	20 10 10 10 10 10 10 10 10 10 10 10 10 10	1	100	XXXX	4.0			1234	45678	
MMDD YY		1	7	47600	W3	5 10 10 10 10 10 10 10 10 10 10 10 10 10	1		XXXX	8.0			123	45678	
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						100 100 100 100 100 100 100 100 100 100							1		
25. FEDERAL TAX I.D. I	NUMBER SSN	EIN	26.	PATIENT'S AC 1234JE		27. ACCEF (For gov	T ASSIGNMEN 1. claims, see ba	IT? ack)	28. TOTAL CHARGE	7	9. AMOUNT	PAID X XX	1	ANCE DUE	
						YES	NO	İ	9	. [ ]	9	1	\$		
	ES OR CREDENTIA	LS			DDRESS OF FA f other than hon	ACILITY WHERE ne or office)	SERVICES WE	HE	33. PHYSICIAN'S, SU & PHONE #		BILLING NA	AME, ADD	HESS, ZIF	CODE	
	ements on the reverse are made a part there								I.M. Billi	_					
									1 W. Wil	lliams	S		- <b>-</b>	_	
I.M. Authorize	ed MM/DD/Y	<b>Y</b>							Anytowr	ı, WI	55555 GRP#	876	65432	1	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500